STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155291	A. BUILDING 00		COMPLETED 05/10/2012	
		155291	B. WING		05/10/2012	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
	/ALLEY MEADOW	0		ALLEY FARMS RD		
EAGLE \	/ALLEY MEADOW	5	INDIAN	NAPOLIS, IN 46214		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	TD1 : ::, C		F0000	The creation and submission	of	
		or the Investigation of	1,0000	this Plan of Correction does n		
	Complaint IN00	0106874.		constitute an admission by thi		
				provider of any conclusion se		
		1106874 - Substantiated.		forth in the statement of		
	Federal/State de	eficiencies related to the		deficiencies, or of any violatio	n of	
	allegations are c	eited at F157.		regulation. This event		
				occurred prior to the compliance date of March 23		
	Survey Dates: 5	5/9/12 and 5/10/12		2012 where the facility did	,	
				correct the system as		
	Facility Number	r: 000188		evidenced by a re-visit surve	Э у	
	Provider Numbe			on 04/10/12 where the ISDH		
	AIM Number:			found the facility to be in		
		10020010		compliance. This provider		
	Survey Team:			respectfully requests that the 2567L Plan of Correction be		
	Heather Lay, RN	N TC		considered the Letter of Cred	ible	
				Allegation and requests a Des		
	Melanie Strycke	EI, KIN		Review in lieu of a Post Surve	ey .	
	Census Bed Typ	oe:		revisit on or after June 01, 20	12.	
	SNF: 9					
	SNF/NF: 98					
	Total: 107					
	10.001. 107					
	Census Payor T	vne·				
	Medicare: 20	7 K				
	Medicaid: 69					
	Other: 18					
	Total: 107					
	10tal. 107					
	Sample: 04					
	1	reflects state findings nce with 410 IAC 16.2.				
	cited in accorda	nce with 410 IAC 16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V5J011

Facility ID:

000188

TITLE

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	сом 05/1	E SURVEY PLETED 0/2012	
	PROVIDER OR SUPPLIER VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	Quality review completed on May 14, 2012, by Bev Faulkner, RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V5JO11

Facility ID: 000188

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS			STREET 3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD JAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must im resident; consult and if known, not representative or member when the resident which the potential for rintervention; a significantly (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative or when there is a change in resident and a change in resident and the consequences of the facility must resident and the representative or when there is a change in resident and the consequences of the facility must resident and the representative or when there is a change in resident and the consequences of the facility must update the addresses the consequences of the facility must update the addresses the consequences of the facility must update the addresses the consequences of the facility must update the addresses the facility must update the facility m	NE/ROOM, ETC) Immediately inform the with the resident's physician; tify the resident's legal ran interested family Idere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial terioration in health, mental, status in either life litions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a). also promptly notify the nown, the resident's legal rinterested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in			
	Based on record facility failed to representative of	review and interview, the notify a resident's legal two significant changes condition. The deficient d 1 of 1 residents	F0157	It is the practice of this facility immediately inform the resident consult with the resident's physician; and if known, notify resident's legal representative an interested family member	the

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Event ID: V5JO11

Facility ID: 000188

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			00	COMPL	ETED
15529		155291	A. BUII			05/10/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
FAOLEN	/ALLEY MEADOW	2			ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	5		INDIAN	IAPOLIS, IN 46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed for lack	k of notification for			when there is an accident		
	significant chang	ge in a sample of 4			involving the resident which		
	residents. [Residents]	dent Bl			results in injury and has the		
					potential for requiring physicial intervention; a significant cha		
	Findings include				in the resident's physical, me	-	
	Tilluligs illelude	.			or psychosocial status (i.e., a		
					deterioration in health, menta		
		5 P.M., Resident B's			psychosocial status in either	•	
	record was revie	wed. Diagnoses			threatening conditions or clin	cal	
	included, but we	ere not limited to, diabetes			complications); a need to alte	er	
	mellitus type II,	insomnia, peripheral			treatment significantly (i.e., a		
	vascular disease.				need to discontinue an existing	•	
	1	perlipidemia, left heel			form of treatment due to adve		
		e ulcer, and dementia.			consequences, or to commer new form of treatment); or a	ice a	
	stage III pressure	e uicei, and dementia.			decision to transfer or discha	rae	
					the resident from the facility a	-	
		ata Set" screening, dated			specified in 483.12 (a). This		
	1/18/12, include	d, but was not limited to,			facility will also promptly notif	y the	
	"Brief Interview	Mental Status: 3 [severe			resident and, if known, the		
	impairment] A	mbulation: 3/2			resident's legal representative		
	1 1	of one staff member],			interested family member wh		
	_	ensive assist of one staff			there is a change in roommat	:e	
	member]"	ensive assist of one staff			assignment as specified in 483.15 (e)(2); or a change in		
	illelliber j				resident rights under Federal	or	
					State law or regulations as	O.	
	"Resident Progre	ess Notes," dated 1/25/12			specified in paragraph (b) (1)	of	
	at 12:29 P.M., in	cluded, but was not			this section. This facility will		
	limited to, "Resi	dent [B] presents with			record and periodically updat		
	increased somno	olence, head down			address and phone number of		
	sleeping in whee	elchair. Resident not as			resident's legal representative	e or	
		responsive to staff			interested family member.	:11	
	1	resents with noted			What corrective action(s) will be accomplished for those	Ш	
	_	ty level has not			residents found to have bee	n	
		•			affected by the deficient	•••	
		n wheelchair as in prior			practice? -Resident B no lo	nger	
		D. notified new order			resides at the facility. How	•	
		lol [anti-psychotic that			you identify other residents		
	can cause letharg	gy] family notified"			having the potential to be		

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Event ID: V5JO11

Facility ID: 000188

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM		COMPLETED	
		155291				05/10/2012
			B. WIN		ADDRESS OF STATE ZID CODE	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE	
					ALLEY FARMS RD	
EAGLE V	ALLEY MEADOWS	5		INDIAN	APOLIS, IN 46214	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					affected by the same deficier	nt
	Resident R's pro	gress notes from 1/26/12			practice and what corrective	
	_	_			action will be taken?	
		nted the resident was up			-Residents residing in the facil	ity
	_	awaken, and alert and			have the potential to be affected	ed
	oriented to perso	on after a change in			by the alleged deficient praction	
	medications.				-Residents' family will be notifi	
					of any change in condition. W	
	"Resident Progra	ess Notes," dated 2/11/12			measures will be put into pla	
	_				or what systemic changes wi	ill
		ncluded, but was not			you make to ensure that the	
	· ·	nedications held related			deficient practice does not	,
	to resident [Resi	dent B] being very			recur? -The Staff Developme	ent
	lethargic this shi	ft [2-10 P.M.]. Has slept			Coordinator will re-educate	
		ontinue to monitor"			licensed nurses on Resident	/12
					Change in Condition by 05/29/ -The interdisciplinary	12.
	D				team/nursing supervisor will	
		related to the notification			review progress notes and	
		egal representative			physician orders daily to ensur	re
	regarding change	e in condition on 2/11/12,			that family has been notified or	
	was not found.				any new physician orders and	
					changes in condition. If family	,
	A "Medication A	Administration Record,"			and physician are not notified	
		ough 2/29/12, indicated			appropriate action will be take	n.
		•			How the corrective action(s)	
		were held for 2/11/12. No			will be monitored to ensure t	-
	doses were mark	ted as given for 2/11/12.			deficient practice will not rec	ur,
					i.e., what quality assurance	_
	"Resident Progre	ess Notes," dated 2/12/12			program will be put into plac	
	_	eluded, but was not			-A Change in Condition CQI	
	· ·	dent has two open areas			will be utilized weekly times fo weeks, monthly times three	ui
		ottom Will continue to			months, and then quarterly	
		ottom win continue to			thereafterData Collected wil	ll be
	monitor"				submitted to the CQI committee	
					for review. If threshold of 100%	
	Documentation of	of the notification of			not achieved, an action plan w	rill
	Resident B's lega	al representative			be developed. Completion Dat	te:
		pen areas identified on			June 1, 2012	
	2/12/12, was not	-				
	2/12/12, was 110t	Touriu.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155291	B. WIN	G		05/10/	2012
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS			<u>, </u>	3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN 46214		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
TAG	On 5/9/12 at 3:20 Resident B's legar member and the procedure on not change was requirector. On 5/10/12 at 4:1 the Executive Discould not provide family notification open areas identified by the example of the examp	O P.M., notification of all representative or family facility policy and diffication of significant ested from the Executive 15 P.M., in an interview, rector indicated she documentation of on of Resident B's new affed on 2/12/12; however de a written statement ation of Resident B's 12.		TAG	DEFICIENCY		DATE
	· ·	out was not limited to,					
	lethargic on my 2	ident B] was very					
		e held because it was					
		M.D. notified and					
	daughter"	n.D. notified and					
	2/11/12, not 2/7/	in question was for 12. The facility was e documentation of esident B's legal					

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AND PLAN (OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 0/2012
	ROVIDER OR SUPPLIER		STREET 3017 V	ADDRESS, CITY, STATE, ZIP C 'ALLEY FARMS RD NAPOLIS, IN 46214	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	significant chang provide documer	family notification of				
		ecutive Director of the facility's policy "Resident Change of				
	dated 3/10, included, "Policy: It is all changes in rescommunicated to family/responsib appropriate, time intervention occur. Change: The rescontified that there the resident's combeing taken Ro The nurse in change.	ly, and effective urs Acute Medical ponsible party will be the has been a change in dition and what steps are utine Medical Change: trge is responsible for				
	assigned shift whin the resident's c	aysician and le party prior to end of uen a significant change condition is noted" relates to Complaint				

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Event ID: V5JO11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155291	A. BUILDING	00	COMPLETED 05/10/2012
		100201	B. WING	ADDDECC CITY OTATE OF CODE	00/10/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD	
	ALLEY MEADOWS		INDIAN	APOLIS, IN 46214	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	REGUENTORT OR	ESC IDENTIFICAÇÃO NA ORMATION	1710	·	DATE

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